

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1912	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/15/2012
NAME OF PROVIDER OR SUPPLIER IMPERIAL GARDENS HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE MADISON, TN 37115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments Complaint investigation #30259 was completed at Imperial Gardens Health and Rehabilitation on August 13, 2012. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 001		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

ADMINISTRATOR

(X6) DATE

9.6.2012

6899

30ZY11

If continuation sheet 1 of 1

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